

Northwest Center for Outcomes Research in Older Adults: A VA HSR&D Center of Excellence



Medical Centers - Seattle, WA & Portland, OR

Winter 2001

*Affiliated with the University of Washington School of Public Health and Community Medicine,
Seattle, WA & Center for Health Research (Kaiser Permanente), Portland, OR*

Performance of a Pharmacy-based Risk Adjustment Measure in a VHA Population

Anne E.B. Sales PhD, Kevin Sloan MD, Chuan-Fen Liu PhD

This study presents results of the first known attempt to tailor a pharmacy-based risk adjustment measure to a VA population. Our original intent was to compare the performance of this newly developed measure with known, validated, and commercially available measures currently on the market. Risk adjustment is an important part of assessing the performance of health care systems. Risk adjustment methods characterize the mix of patients in a provider panel, facility, or health care system in terms of the number and severity of medical conditions documented for each patient. This process allows health care systems to anticipate costs and plan for the health care needs of their patients.

Most widely used risk adjustment methods today are based on patient diagnoses, recorded as ICD-9 diagnosis codes in patient records. There are some disadvantages of diagnosis-based risk adjustment, however, including the potential for incomplete diagnosis data in hospital databases, errors and omissions in coding diagnoses during a patient

visit, and “gaming” of diagnoses to increase reimbursement to providers or health care systems. For these reasons, there has been increasing interest in risk adjustment methods based on pharmacy data. The logic behind such methods is that individuals with chronic illnesses such as diabetes or hypertension are frequently prescribed a set of specific, identifiable drugs. Prescribing practices, especially the use of multi-drug regimens to treat a single condition, may provide information about disease severity. In addition, pharmacy data are less subject to “gaming” by providers than diagnosis data because of the greater consequences of manipulating drug choices, and therefore may be more reliable indicators of actual disease state. The purpose of this study was to modify an existing pharmacy-based risk adjustment measure (RxRisk) for use in VA, and to compare its performance to diagnosis-based risk adjustment methods in a VA population. Previous versions of RxRisk have proven valid and reliable predictors of future health care costs in

the commercial sector and appear to perform similarly to the more widely used, diagnosis-based risk adjustment methods. This study created RxRisk-V, a pharmacy-based risk adjuster for predicting VA costs and utilization of health care resources using patient age, sex, and chronic disease classes defined by prescription drug fills. Our primary research question asked whether the RxRisk-V is better able to predict costs than three other leading risk adjustment methods: the original version of RxRisk, and two leading diagnosis-based risk adjustment methods, Adjusted Diagnostic Groups (ADGs, a component of Adjusted Clinical Groups) and Hierarchical Coexisting Conditions (HCCs, a refinement of Diagnostic Cost Groups). The study population consisted of all veterans seen in any outpatient treatment clinic in seven VA medical facilities in VISN 20 during Fiscal Years (FY) 1996 - FY98, 10/95–9/98. The term “outpatient

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Emblem: "Soul Catcher" ...a Northwest Coast Indian symbol used to ward off spirits that brought physical or mental illness. Artist: Marvin Oliver.

treatment clinics” includes all regular medical, surgical, mental health and emergency clinics. The seven facilities in our sample represent both urban and rural areas in four states, supporting generalizability across large portions of the VA national system.

Data were extracted from the VISN 20 Data Warehouse, a relational data warehouse mirroring most of the key elements of the clinical information system for all facilities in VISN 20. Data elements of the analytic data set of three-year veteran users include pharmacy (all drugs prescribed and filled), diagnoses from inpatient and outpatient data, and patient demographic variables. We constructed the RxRisk-V using VA drug classes. Cost data were drawn from the Decision Support System in seven of the eight sites. We compared the predictive power of RxRisk-V to that of ADGs, HCCs, and the original RxRisk using the VISN 20 veteran three-year user population. We used outcome data from two sequential 12-month periods (FY 1998 and 1999) to examine the ability of each risk adjustment model to predict concurrent and prospective costs.

The study population was split into an estimation sample (80,562 veterans) and a validation sample (80,640 veterans). Study population characteristics were very similar between estimation and validation samples. The study population as a whole was 94% male, with a mean age of 55. More than half (54%) were classified into at least one RxRisk-V category, 75% classified into at least one DCG/HCC category, and 75% classified into one of the ADG categories.

We compared predicted costs to actual FY 98 costs. Next, we regressed FY 99 costs on FY 98 explanatory variables for the estimation sample. We predicted FY 99 costs for the validation sample and compared predicted costs to actual FY 99 costs. Finally, we explored mixed models by combining summary scores from the DCG/HCC measure with categories from RxRisk-V.

Among current year cost models, the DCG/HCC model performs best in terms of validation R^2 (0.45), followed by ADG (0.31), RxRisk-V (0.20), RxRisk (0.18), and the age/sex model (0.01). The prospective cost models, except for the age/sex model ($R^2 = 0.01$), have comparable validation R^2 . The DCG/HCC model has the highest R^2 (0.15), followed by ADG (0.12), RxRisk-V (0.12), and RxRisk (0.11).

We also explored the performance of combined models, including both RxRisk-V and HCCs, using the estimation sample to predict DSS total costs. The results indicate that combined models for predicting costs have only limited impact on estimation R^2 . Combining HCCs and RxRisk-V, including

age/sex categories, the concurrent estimation R^2 is 0.483 in predicting total cost, which is only slightly greater than the HCC model alone (0.474). The combined prospective estimation R^2 (0.176) is greater than the HCC (0.165) model.

From our results, it is clear that RxRisk-V does not perform better than the most sophisticated diagnosis-based measure available on the market, the DCG/HCC system. The DCG/HCC system appears to predict costs most accurately both in the current year and prospectively in this VA population. However, as with the ACG/ADG system, DCG/HCC grouping is proprietary, and further development and tailoring for VA are not possible without access to the proprietary code. ADGs appear to predict costs in the current year and prospectively less well than HCCs, and RxRisk-V's predictive power is less than that of the ADGs.

We did not initially anticipate that RxRisk-V, the VA-tailored measure, would greatly outperform existing risk adjustment measures. We hypothesized that it might out-perform the diagnosis-based measures because of the nature of pharmacy-based patient risk classification: not reliant on coding and or subject to potential errors associated with coding, possibly less susceptible to gaming, and more likely to be available and applicable to a larger number of users. RxRisk-V does not perform better than diagnosis-based measures available on the market. However, it is within acceptable limits of performance by comparison with ADGs.

One of the primary advantages of the RxRisk over the more widely known diagnosis-based, proprietary risk adjustment measures is that it is non-proprietary and available as open-source code; its availability makes it a very attractive tool for use in public sector agencies such as VA. We are developing a User Manual to accompany the SAS code we have constructed during this project, and will make it available on request to other users within and outside VA.

We have used RxRisk-V to risk adjust for only a few of the possible outcomes of interest to VA managers, clinicians and researchers. Our primary interest was in comparing its performance on cost outcomes with commercial risk adjustment measures because of the intense interest in costs for allocating resources and comparing among facilities. In addition, we examined its performance in adjusting a common utilization measure of interest to providers and managers, outpatient visits. In each of these cases, we found that RxRisk-V does not adjust risk as well as the proprietary diagnosis-based systems, but performs reasonably compared to age/sex adjustment.

(Submitted for publication in 2002)

Cardiovascular Risk Factor Control Among Veterans with Diabetes, NL Smith, L Chen, DH Au, M McDonell, SD Fihn

OBJECTIVES: To describe the extent to which hyperglycemia, hypertension, and dyslipidemia are currently detected, treated, and controlled in US veterans with diabetes with and without ischemic heart disease (IHD).

METHODS: 3769 veterans who self-reported diabetes and who received all health care from Veteran Affairs (VA) medical centers were selected from subjects enrolled in the Ambulatory Care Quality Improvement Project, a randomized health services intervention at 7 VA primary care clinics. IHD was defined by a self-reported history of myocardial ischemia, infarction, or revascularization. Mean values of hemoglobin A1c (HbA1c), blood pressure, and cholesterol sub-fractions were collected from computerized laboratory databases. Medication data were collected from computerized pharmacy databases.

RESULTS: Mean HbA1c and optimal control (HbA1c<7%) did not differ for those without and with IHD: 8.1% and 8.0%; 26% and 24%, respectively. Veterans with IHD were more likely to have hypertension (73% versus 64%), to be treated (88% versus 78%), and to have optimal blood pressure control (19% versus 10%) compared to Veterans without IHD, all p-values <0.01. Veterans with IHD were more likely to have dyslipidemia (81% versus 53%), were equally likely to be treated (54% versus 50%) and were more likely to have optimal LDL levels (30% versus 16%) compared to veterans without IHD, all p-values <0.01.

CONCLUSIONS: Optimal cardiovascular risk factor control was the exception in this cohort of diabetic Veterans attending primary care clinics.

IMPACT STATEMENT: More aggressive management of cardiovascular risk factors in veterans with diabetes may be warranted, especially among those without prevalent IHD.

Cost Evaluation in a Clinical Trial of Therapeutic Footwear, Matthew L. Maciejewski, Gayle E. Reiber, Doug Smith

OBJECTIVES: To evaluate ulcer-attributable and overall cost differences across three arms of a clinical trial of therapeutic footwear for patients with diabetes at high risk for reulceration. We also examined costs between VA patients and non-VA patients enrolled in the trial.

METHODS: Cost data for 392 patients in a clinical trial of therapeutic footwear was obtained from DSS

cost accounting systems being used by the VA and non-VA health system from which study patients were drawn. Ulcer-attributable utilization and costs were identified from primary CPT-4 procedure codes and ICD-9 diagnosis codes related to ulcers and abnormal skin conditions, peripheral vascular disease and other conditions. Intervention costs related to study visits, calls, shoes, inserts and slippers were captured in administrative records maintained by study staff.

RESULTS: There were no significant differences in resource use of any kind across the three study arms, with the exception of study shoes, insoles and slippers. Arm 1 and Arm 2 participants had study shoe costs that were significantly higher than Arm 3 participants. Despite the higher study shoe costs in Arms 1 and 2, there were no significant offsets in health care costs. Two-year ulcer-attributable outpatient costs were \$497, \$515, and \$603 for participants in Arms 1, 2, and 3, respectively. Two-year ulcer-attributable inpatient costs were \$416, \$403, and \$589 in Arms 1, 2, and 3, respectively. While VA and non-VA utilization was not significantly different, costs for VA patients were nearly twice as high as costs for non-VA patients.

CONCLUSIONS: The provision of therapeutic footwear had no clinical benefit or cost offset for patients with diabetes at high-risk for reulceration. Inpatient and outpatient care for high-risk VA patients with diabetes appears to be twice as expensive as health care for similar patients in a non-VA setting.

IMPACT STATEMENT: VA administrators may want to reconsider therapeutic footwear benefits for veterans with similar characteristics as those in this trial, in light of insignificant clinical benefits and cost offset that was observed. Other types of interventions may necessary to reduce the reulceration rates in this group of veterans.

Case-mix Measures Derived from Self-Report of Diagnoses and Health: the Seattle Index of Comorbidity, VS Fan, DH Au, P Heagerty, RA Deyo, MB McDonell, SD Fihn

OBJECTIVES: Self-reported chronic diseases and health status are associated with resource use. However, few data exist regarding their ability to predict mortality or hospitalizations. We sought to determine whether self-reported chronic medical conditions and the SF-36 could be used individually or in combination to assess comorbidity in the outpatient setting.

METHODS: We conducted a prospective cohort study using data from patients participating in the Ambulatory Care Quality Improvement Project (ACQUIP) conducted at 7 Veterans Affairs (VA) medical centers. We identified 10,947 patients \geq 50 years of age enrolled in general internal medicine clinics who returned both a baseline health inventory checklist and the baseline SF-36 who were followed for a mean of 722.5 (sd 84.3) days. The primary outcome was all-cause mortality, with a secondary outcome of hospitalization within the VA system.

RESULTS: Using a Cox proportional hazards model in a development set of 5469 patients; a comorbidity index (Seattle Index of Comorbidity [SIC]) was constructed using information about age, smoking status and 7 of 25 self-reported medical conditions that were associated with increased mortality. In the validation set of 5478 patients, the SIC was predictive of both mortality and hospitalizations within the VA system. A separate model was constructed in which only age and the PCS and MCS scores of the SF-36 were entered to predict mortality. The SF-36 component scores and the SIC had comparable discriminatory ability (AUC for discrimination of death within 2 years 0.71 for both models). When combined, the SIC and SF-36 together had improved discrimination for mortality (AUC=0.74, p-value for difference in AUC < 0.005).

CONCLUSIONS: A new outpatient comorbidity score developed using self-identified chronic medical conditions on a baseline health inventory checklist was predictive of 2-year mortality and hospitalization within the VA system in general internal medicine patients.

IMPACT STATEMENT: This study suggests that a brief self-administered questionnaire with 9 items, including 7 chronic medical conditions, age and smoking status can be used to adjust for comorbidity in outpatient studies. Alternatively, if the SF-36 is available, the PCS and MCS might also be used as a general measure of comorbidity.

Routine Reporting of Health Status Data Does Not Improve General Health or Satisfaction, SD Fihn, MB MCDonell, DH Au, M Burman, V Fan, P Diehr

OBJECTIVES: Prior studies of short-term feedback of general health status measures to providers have not improved patients' overall health. We hypothesized that sustained reporting of general and condition-specific measures in a sophisticated graphical format would improve patients' health and satisfaction.

METHODS: We conducted a group-randomized effectiveness trial in GIM clinics at 7 VA facilities with 2 or more discrete firms. All patients with a primary provider and an appointment in the last year were eligible. Respondents to a baseline health inventory were regularly mailed the SF-36, a patient satisfaction questionnaire, and, as relevant, validated questionnaires about 6 chronic conditions: coronary disease, COPD, depression, diabetes, alcohol use and hypertension. We computed SF-36 physical and mental component scales (PCS and MCS). Clinical data were retrieved from VistA. Data were graphically reported to providers of eligible patients at every visit for 2 years (e.g., blood pressure, HbA1C, SF-36 scale scores anginal frequency) as well as "tips" derived from national guidelines. Clinicians received summaries comparing their panels with local/national norms and training on quality improvement and interpretation of health status measures.

RESULTS: Of 34,103 eligible patients in an entry cohort, 22,223 returned baseline health inventories. Of these, 15,346 returned a subsequent mailing. Over 300 000 questionnaires were mailed, and over 44,000 feedback reports were distributed. After adjustment for baseline, mean changes in PCS and MCS scores over 2 years in intervention firms were not significantly different from controls (-7.28 [sd 1.15] vs -6.63 [sd 1.04] and -3.63 [sd 1.43] vs -3.83 [sd 1.71], $p > .10$) in paired analyses. There were no significant differences in condition-specific health measures and satisfaction between groups after controlling for provider type, panel size, and number of visits or restriction to patients who completed all forms.

CONCLUSIONS: Routine collection and feedback of general and condition-specific measures of health and satisfaction did not improve outcomes. Such data should likely be linked to specific management suggestions if they are to improve patients' outcomes.

IMPACT STATEMENT: Results should be highly valuable to individuals responsible for quality improvement in large health care systems, such as VA, in planning and applying results of large-scale surveys.

FELLOWS' PROFILES

David Arterburn, MD

David is a first year research fellow in HSR&D. He is a graduate of Murray State University in Murray, KY and the University of Kentucky College of Medicine in Lexington. David recently completed his residency and chief residency in Internal Medicine at the University of Texas Health Science Center at San Antonio. While in Texas, David worked closely with Cynthia Mulrow and W. Scott Richardson of VERDICT, another HSR&D Center of Excellence. He received training in the methodology of systematic reviews, and he published evidence reports on idiopathic deep vein thrombosis and obesity pharmacotherapy. While in Seattle, David will be pursuing a Masters of Public Health in Health Services at the University of Washington.

David's research interests include the cost and quality of care for patients with obesity. His current projects include: a systematic review of the evidence for weight loss and harms associated with the drug sibutramine (Meridia), a cost-effectiveness analysis of sibutramine for weight loss, and the development of a model to predict changes in obesity prevalence over time. He is collaborating with Paul Crane, David Veenstra, and Sean Sullivan of the University of Washington.

Having recently moved to Washington, David has been using all of his free time to hike and mountain bike areas around the Puget Sound with his wife, Jennifer, and one-year old son, Sam. Jennifer, a technical writer, is a graduate of Murray State University and Miami of Ohio, and she currently works for CH2M Hill of Bellevue. David also recently completed his first two half marathons in Olympia and Seattle.

Ann Hightower, MD

Dr. Ann Hightower is a first-year VA HSR&D fellow. Dr. Hightower completed her medical school education at Northwestern University followed by internal medicine residency at University of Texas Health Science Center at San Antonio. After residency training, she practiced internal medicine in northern California. She returned to San Antonio and was a staff physician at the Audie Murphy VA Hospital in San Antonio and clinical assistant professor in the division of General Medicine at the University of Texas Health Science Center-San Antonio. Subsequently, she worked at Madigan Army Medical Center in the Department of Medicine in the Adult Primary Care Clinic there.

Two years ago she completed a fellowship in Geriatric Medicine at VA Puget Sound Health Care System-American Lake Division. She spent a subsequent year at American Lake as a long-term care resident and became involved in clinical research activities with the Memory Wellness Research Program at that site.

Currently Ann is pursuing additional training in epidemiology as an HSR&D fellow. Her research interests are Alzheimer's disease in ethnic elders and in improving the quality of cognitive assessment in the elderly.

Kent Hu, MD

New to the northwest, Kent Hu joins us at HSR&D as one of our new ambulatory care fellows. Born in New York, Kent has spent most of his training in the northeast. Kent attended Columbia College at Columbia University in NYC and completed his medical education at Yale University. He then trained in Internal Medicine at the University of Pennsylvania.

Kent has had a longstanding interest in international infectious disease epidemiology and health services. During college, he spent eight months in northern India, Nepal and Tibet, studying the modern transformation of traditional Tibetan medicine and Buddhism. During medical school, he completed his MD thesis on the clinical manifestations of malaria in a Burmese refugee camp in northern Thailand. He later worked with various non-government organizations in Nepal, teaching local health care providers and helping with the integration of western medical aid programs. Kent's current research interests focus on the management of tuberculosis in immigrants and refugees to the United States.

Kent and his wife, Jennifer are enjoying having Seattle as their new home. Jennifer is a pediatrician at Seattle Children's Hospital. They spend much of their time hiking in the mountains and paddling in Puget Sound.



Bevan Yueh, MD

Bevan Yueh has been an investigator in the Health Services Research and Development Center of Excellence at the VA Puget Sound Health Care System, Seattle since 1997. He came to VA Puget Sound after completing a Robert Wood Johnson Clinical Scholars fellowship at Yale University under the tutelage of Alvan Feinstein. Previously, he completed a residency and fellowship in Otolaryngology—Head and Neck Surgery at the John Hopkins Hospital in Baltimore, Maryland.

Bevan's clinical practice centers on head and neck surgical oncology, but his research interest is focused on hearing loss and hearing amplification for older veterans. He received an Advanced Research Career Development Award from VA to study optimal methods for detecting and treating hearing-impaired veterans. He has completed a randomized trial studying the relative effectiveness of different methods for hearing amplification. He is currently developing the instruments that will be used to gain insight into the hearing-related quality of life of patients receiving treatment for hearing loss to be called the Inner and Outer EAR. Bevan is the Principal Investigator for the VA-funded randomized trial on Screening for Auditory Impairment (SAI-WHAT). This trial seeks to identify which hearing assessment test will most effectively identify the hearing-impaired veterans who are likely to benefit from treatment.

Bevan and his wife Teresa have been blessed with two wonderful children, 3-year-old Cassidy and 1-year-old Spencer. Bevan and Teresa have thoroughly enjoyed having their lives run ragged in their futile attempts to keep their lives in some semblance of order.

Northwest HSR&D Center of Excellence

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HSR&D Newsletter

Contributions for the Northwest HSR&D COE Newsletter should be sent to:

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HSR&D Deadlines

Local deadline for proposal review is two weeks prior to Research Review Committee meeting and two months prior to VACO deadline. Local Review Committee meets on 1st Friday of each month.

VACO Deadlines

Letters of Intent (LOI): Accepted any time, reviewed monthly. Guidelines found in VHA Handbook 1204.01.

Investigator-Initiated Research (IIR) and Nursing Research Initiatives (NRI) Proposals: Due May 1 and November 1. An approved LOI is required prior to submission. Guidelines found in VHA Handbook 1204.01.

Research Career Scientist Awards: March 1 and September 1. Guidelines found in VHA Handbook 1204.02.

Career Development Awards: Due February 15 and August 15. Must have approved LOI prior to submission; due November 1 and May 1. Guidelines found in VHA Handbook 1204.02.

Under Secretary's Award for Outstanding Achievement in Health Services Research: Submissions due in VACO October 1. Guidelines found in VHA Handbook 1204.04.

For current guidelines and forms, please refer to www.va.gov/resdev

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WHAT'S HAPPENING AT THE NW HSR&D CENTER OF EXCELLENCE

16 Abstracts Accepted for Presentation at 20th Annual HSR&D Meeting

Posters

- Cardiovascular Risk Factor Control Among Veterans with Diabetes, Nicholas Smith, PhD
- Educating for Professionalism: Medical Trainees' Emotions on Hospital Wards, Deborah Kasman, MD, MA
- Hepatitis C Testing in the VHA NW Network - Prevalence, Risk Markers and Future Recommendations, Kevin Sloan, MD
- Two Software Programs for Providing Training in Global Assessment of Functioning (GAF) Ratings, John Davison, MBA, PhD
- Echocardiography in the Management of Stroke: Systematic Review and Cost-Utility Analysis, Somnath Saha, MD MPH

Oral Presentations

- Change in SF-36 and Risk of Hospitalization and Mortality, Vincent Fan, MD MPH
- Beta-agonists and the Risk of Heart Failure Admission and Mortality Among Patients with Known LVSD, David Au, MD, MS
- Routine Reporting of Health Status Data Does Not Improve General Health or Satisfaction, Stephan Fihn, MD MPH
- Comparison of the SF-36 and SF-12 Summary Scales in a Veteran Population, Mary McDonell, MS
- Relative Performance of the PCS and PCD to Measure Health Status in a Longitudinal Study with Deaths, Paula Diehr, PhD
- Predicting Outpatient Pharmacy Cost Using Diagnosis and Pharmacy-Based Case-Mix Instruments, Kevin Sloan, MD
- Cost Evaluation in a Clinical Trial of Therapeutic Footwear, Matt Maciejewski, PhD
- Outpatient Management of Chronic Stable Angina in VA: Data from the ACQUIP Study, Marcia Burman, MD MPH (de-

ceased), Presented by Stephan D. Fihn, MD MPH

- Case-Mix Measures Derived from Self-Report of Diagnoses and Health: the Seattle Index of Comorbidity, Vincent Fan, MD MPH

Workshops

- Clinical Reminders as Tools for Quality Improvement, Ashley Hedeem, MD MPH
- A Partnership Approach to Disseminating Improved Care Models for Depression to VA Settings, Edmund Chaney, PhD and Lisa Rubenstein, MD MPH combined with,
- Translation Methods: Shaping Health by Linking Research and Practice, Lynn McQueen, DrPH MSMPH

On October 11, 2001, we lost a dear friend and colleague, Dr. **Marcia Burman**. Marcia was born on March 30, 1955 in Kalispel, Montana. She is survived by her husband Dr. Michael Kalnoski and son Maxwell Kalnoski of Seattle, and her parents Ellen and Rudolph Burman of Lakewood, WA. Marcia was a core investigator with HSR&D, a staff physician in the GIMC at the Seattle VA in Seattle, and in her first year as an HSR&D Research Career Development Awardee. Her research interests were in the implementation and effectiveness of clinical practice guidelines. A memorial fund for Marcia has been set up as an educational account for her son Max. Please contact Shannon Grimm, 206.764.2651 for details.

Newly Funded HSR&D/DVA Projects - In Seattle, Audiology Visits After Screening for Hearing Loss: An RCT, Bevan Yueh, MD, PI; Evaluation of Community Based Outpatient Clinic Costs Using DSS Data, Matthew Maciejewski, PhD, PI; VA Hepati-

tis C Field-Based Resource Centers, Jason Dominitz, MD, MPH; **In Portland**, Improving Outcomes of Depression in Primary Care, Steven Dobscha, MD, PI; Research Career Development Award, Improving Understanding of Racial Disparities in Health Care, Somnath Saha, MD, MPH, Awardee.

New and Departed Investigators - Seattle Site, added to Core Staff Edmund Chaney, PhD, Jason Dominitz, MD, MPH, David Penson, MD, MPH, Career Development Awardee; Edward Perrin, PhD left HSR&D at the end of 2001 to pursue other university research activities; **Portland Site**, added Sherrie Schuldheis, PhD, Jackilen Shannon, PhD, and Steven Dobscha, MD.

Steve Fihn's Sabbatical - This past August, Steve Fihn returned from a year-long sabbatical in the Netherlands. He served as a visiting Professor at the University of Leiden, the oldest university in northern Europe. While in Leiden, he was a member of the Department of Clinical Epidemiology and pursued studies related to the quality and control of chronic anticoagulation therapy. He continued to work on many of his ongoing VA projects including analysis and reporting of the recently completed Ambulatory Care Quality Improvement Project.

Dr. Fihn learned to appreciate the fine points of Dutch life and culture including living without an automobile (a pleasure), being constantly in the rain (just like Seattle), and actually having free time to think and write (a real luxury). In addition, he learned to speak passable Dutch.

Dr. Fihn has settled back into Seattle although since his return, he has been observed to periodically lapse into distracted reveries with images of tulips and windmills.